

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

11203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11173
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Penna b. COUNTY York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural R#60 Hagerstown				c. LENGTH OF STAY IN lb 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Albert Andrew Middle Amsbaugh Last 				4. DATE OF DEATH Month Oct. Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder Foundry & Chain Co.			10b. KIND OF BUSINESS OR INDUSTRY Penna		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 176-01-6242		17. INFORMANT Address Mrs. Pauline E. Bombell- 1601 Va Ave Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO Bone Deep Laceration across rt knee Conditions, if any, which gave rise to immediate cause (b) Closed fractured rt femur DUE TO causing the underlying cause lost. (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head-on automobile collision					
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. Oct. 20 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Rural Hagerstown Wash Md	(County) 	(State) 		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Oct. 21, 1957			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/23/57	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	22d. LOCATION (City, town, or county) York, Penna.	(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant			24a. REC'D BY REGISTRAR Oct. 23, 1957	24b. REGISTRAR'S SIGNATURE Charles H. Bowers			

ILLINOIS STATE DEPARTMENT OF HEALTH - CHICAGO 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		MILITARY SERVICE		OCCUPATION		EDUCATION		SCHOOLING	
WHITE		WHITE		METHODIST		MARRIED		ARMY		CLOCK REPAIRER		HIGH SCHOOL		HIGH SCHOOL	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
NONE		HEART DISEASE		SUICIDE		CHICAGO		OCT 6 1968		10:00 PM		10:00 PM		10:00 PM	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		SIGNATURE OF WITNESS		TITLE OF WITNESS		SIGNATURE OF JURY		TITLE OF JURY		SIGNATURE OF JURY		TITLE OF JURY	
JAMES EARL RAY		MEDICAL EXAMINER		JAMES EARL RAY		WITNESS		JAMES EARL RAY		JURY		JAMES EARL RAY		JURY	

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 OCT 28 1968
 BUREAU V. 3

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11163

CERTIFICATE OF DEATH

11174

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MATYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 10 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 701 E. ANTIETAM ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ETHEL Middle LORRAINE Last BAKER				4. DATE OF DEATH Month OCT. Day 7 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/24/1913	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS				10b. KIND OF BUSINESS OR INDUSTRY DRESS CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLAM BAKER				14. MOTHER'S MAIDEN NAME MARY C. REED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 561-38-6370		17. INFORMANT MRS. OTTIE CRILLEY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular Collapse. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vas. Accident DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-27-56 , 19__, to 10-7-57 , 19__, that I last saw the deceased alive on 10-7-57 , 19__, and that death occurred at 5 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis G. Graff M.D.				ADDRESS (Street, city or town, state) 119 E. Antietam			
DATE SIGNED 10-7-57							
PHYSICIAN'S NAME (Type) Louis G. GRAFF-M.D.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/9/57		22c. NAME OF CEMETERY OR CREMATORY GREENWAY CEM.		22d. LOCATION (City, town, or county) (State) BERKLEY SPRINGS W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 9/19/57	
				24b. REGISTRAR'S SIGNATURE Chas. Powers			

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11204

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R.F.D.				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Welty Middle Baker Last Sr.				4. DATE OF DEATH Month 10 Day 19 Year 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Furnace Tender		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Baker				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-05-6223		17. INFORMANT Welty Baker Jr. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Chr. Endocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Chr. Endocarditis DUE TO (c) Chr. Endocarditis						INTERVAL BETWEEN ONSET AND DEATH 1 week 4 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb Aug 1, 1957 to Oct 19, 1957 , that I last saw the deceased alive on Oct 19, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md DATE SIGNED 10/21/57			
PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY Manor		22d. LOCATION (City, town, or county) (State) Tilghmanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Oct 25-57		24b. REGISTRAR'S SIGNATURE Leroy M. Forkner (Deputy)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 30 1957

BUREAU V. S.

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		MAY 1957	
MEMORANDUM FOR THE DIRECTOR		SUBJECT: [Illegible]	
TO: [Illegible]		FROM: [Illegible]	
RE: [Illegible]		DATE: [Illegible]	
1. [Illegible]		2. [Illegible]	
3. [Illegible]		4. [Illegible]	
5. [Illegible]		6. [Illegible]	
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91. [Illegible]		92. [Illegible]	
93. [Illegible]		94. [Illegible]	
95. [Illegible]		96. [Illegible]	
97. [Illegible]		98. [Illegible]	
99. [Illegible]		100. [Illegible]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. E. W. Ditto, Jr. 11164 CERTIFICATE OF DEATH

11176
Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 30 yrs.		d. STREET ADDRESS 870 Frederick St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 870 Frederick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ARTHUR Last BARBER		4. DATE OF DEATH Month October Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Janu. 29, 1885
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	
11. BIRTHPLACE (State or foreign country) Hagerstown, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H. Barber		14. MOTHER'S MAIDEN NAME Florentine Arthur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-3638	
17. INFORMANT Mrs. Florentine Barber		Address 870 Frederick St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) 10 yrs			INTERVAL BETWEEN ONSET AND DEATH 30 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 30, 1957 , to Oct 23, 1957 , that I last saw the deceased alive on Oct 15, 1957 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Maryland DATE SIGNED, En. D. H. Jr. M.D.			
ACTUAL SIGNATURE En. D. H. Jr. M.D.			
PHYSICIAN'S NAME (Type) En. D. H. Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-24-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR Oct. 25/1957	24b. REGISTRAR'S SIGNATURE Chas. H. Bowers

OCT 28 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11177

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Md</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Maryland.</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Barnhart</u> Last <u>Barnhart</u>				4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>19 57</u>																	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.22.1909</u>		9. AGE (In years last birthday) <u>48</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>6</u></td> <td><u>6</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>6</u>	<u>6</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>6</u>	<u>6</u>																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Orchard</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>Harry Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Seal</u>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>207-01-5999</u>		17. INFORMANT <u>Lillian P Eddie</u> Address <u>237 Penna.Ave Hancock Md</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns - Charring of head, entire body, upper and lower extremities</u> DUE TO </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> </tr> <tr> <td colspan="2"> DUE TO (b) DUE TO (c) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns - Charring of head, entire body, upper and lower extremities</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns - Charring of head, entire body, upper and lower extremities</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
DUE TO (b) DUE TO (c)																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>																					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned when trailer caught afire</u>																	
20c. TIME OF INJURY Month, Day, Year <u>10:10 p.m. Oct. 28 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Rural Hancock Wash Md</u>															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>S. Robert Wells</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-1-57</u>																	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11.3.58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge Cemetery</u>		22d. LOCATION (City, town, or county) <u>Near Hancock Washington Md.</u>															
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honored P. Stone Hancock Md</u>				24a. READ BY REGISTRAR <u>DATE 11/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. A. Veller</u>															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 5 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Brewer

11206 CERTIFICATE OF DEATH

11178
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown-RFD				c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle ELIZABETH Last BARTLE				4. DATE OF DEATH Month October Day 14 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1863	
9. AGE (In years last birthday) 94 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Clearspring, Wash. Co.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Mouse		14. MOTHER'S MAIDEN NAME Mary Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ernest L. Bartle-341 Mealy Pkwy.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Dis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 52 to Oct 15 , 19 57 , that I last saw the deceased alive on Oct 14 , 19 57 , and that death occurred at 6:50 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md		DATE SIGNED 10/15/57	
PHYSICIAN'S NAME (Type) David R. Brewer				Clear Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-57		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cath. Ceme.-Clearspring, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR OCT 17 1957	
				24b. REGISTRAR'S SIGNATURE Chas H. Bowers			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 1/2 SOUTH STREET, BALTIMORE, MD.		ATTORNEY AT LAW		HIGH SCHOOL		MARRIED		MAY 1, 1957		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF CORONER	
HEART DISEASE		NATURAL		JAMES EARL RAY		JOHN J. HARRIS		JAMES EARL RAY		JOHN J. HARRIS	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
MAY 1, 1957		BALTIMORE, MD.		MAY 1, 1957		BALTIMORE, MD.		MAY 1, 1957		BALTIMORE, MD.	

BUREAU V. B.

OCT 17 1957

RECEIVED

11207
CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 CLEAR SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) 105 CUMBERLAND ST		d. STREET ADDRESS 105 CUMBERLAND ST.	
3. NAME OF DECEASED (Type or print) First Middle Last GRANVILLE N. BAUBLITZ		4. DATE OF DEATH Month Day Year 10 15 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 17, 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY VARIETY STORE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NELSON BAUBLITZ		14. MOTHER'S MAIDEN NAME MARY MORAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 300-18-1045	
17. INFORMANT MRS. MARY L. BAUBLITZ		Address CLEAR SPRING, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION DUE TO (c) CORONARY ARTERY ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES 2 HOURS 3 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 24, 1954, to OCTOBER 15, 1957, that I last saw the deceased alive on OCTOBER 15, 1957, and that death occurred at 10-45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Archie Robert Cohen M.D.	
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND OCTOBER 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/18/57
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS	22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark	ADDRESS Clear Spring, Md.
24a. REC'D BY REGISTRAR DATE 10/18/57	24b. REGISTRAR'S SIGNATURE Joseph M. Murray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

21 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11208

CERTIFICATE OF DEATH

11180

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown #5</u>				c. LENGTH OF STAY IN 1b <u>6 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Rural, Hagerstown #5</u>			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>Ritchie</u> Last <u>Belew</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/9/1947</u>	
9. AGE (In years lost birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Claude T. Belew</u>				14. MOTHER'S MAIDEN NAME <u>Clara J. Lühoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Claude T. Belew</u> Address <u>Hagerstown Md., #5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis, acute -</u> <u>754.4</u> DUE TO <u>URI</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Congenital Heart Lesion?</u> BIRTH -							INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>3-4 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>20 APRIL, 1954</u> to <u>28 OCT., 1957</u> , that I last saw the deceased alive on <u>27 Oct., 1957</u> , and that death occurred at <u>1:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Hyounghs</u> M.D.				ADDRESS (Street, city or town, state) <u>Blue Ridge Summit Pa 29001</u> DATE SIGNED <u>1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Gove, Waynesboro Pa</u>				24a. REC'D BY REGISTRAR <u>Oct. 31, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Powers</u>	

CERTIFICATE OF DEATH

Form No. 10

PLACE OF DEATH HOME		SEX FEMALE		RACE WHITE	
DATE OF DEATH NOV 2 1957		TIME OF DEATH 10:00 AM		PLACE OF BIRTH BALTIMORE, MARYLAND	
NAME OF DECEASED MARY V. S.		AGE 68		OCCUPATION HOUSEWIFE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF INTERMENT CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN J. H. S.		SIGNATURE OF REGISTRAR J. H. S.		SIGNATURE OF WITNESS J. H. S.	
DATE OF SIGNATURE NOV 2 1957		DATE OF SIGNATURE NOV 2 1957		DATE OF SIGNATURE NOV 2 1957	
PLACE OF DEATH HOME		SEX FEMALE		RACE WHITE	
DATE OF DEATH NOV 2 1957		TIME OF DEATH 10:00 AM		PLACE OF BIRTH BALTIMORE, MARYLAND	
NAME OF DECEASED MARY V. S.		AGE 68		OCCUPATION HOUSEWIFE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF INTERMENT CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN J. H. S.		SIGNATURE OF REGISTRAR J. H. S.		SIGNATURE OF WITNESS J. H. S.	
DATE OF SIGNATURE NOV 2 1957		DATE OF SIGNATURE NOV 2 1957		DATE OF SIGNATURE NOV 2 1957	

BUREAU V. S.

NOV 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11209 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11181

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown Legion Home</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>307 Radcliff Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>William George Earl Bennight, Sr.</u>				4. DATE OF DEATH Month Day Year <u>Oct. 19 19 57</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11p - 1918</u>		9. AGE (In years last birthday) <u>39 yrs.</u>		IF UNDER 1 YEAR Months Days <u>9 8</u>		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blueprint Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>				11. BIRTHPLACE (State or foreign country) <u>Henryetta Okla.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tollie T. Bennight</u>						14. MOTHER'S MAIDEN NAME <u>Dean Johnston</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>444-12-8672</u>				17. INFORMANT Address <u>Mrs. Wm. G. E. Bennight Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>advanced arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>None</u>												INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) - - -		(County) - - -		(State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>S. Robert Wells</u> DATE SIGNED EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>						ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 25, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home				d. STREET ADDRESS 110 Washington St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emory Middle McClung Last Booth				4. DATE OF DEATH Month 10 Day 28 Year 19 57			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.19.1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 1 Days 9 Hours Min. 		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Celenese Corp		11. BIRTHPLACE (State or foreign country) Fulton County Penna	
12. CITIZEN OF WHAT COUNTRY? U.S.A?							
13. FATHER'S NAME William Booth				14. MOTHER'S MAIDEN NAME Rachael Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-10-5342A			
17. INFORMANT Mrs Mary E Booth Hancock Maryland.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Mitral Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral Stenosis							
INTERVAL BETWEEN ONSET AND DEATH 4 wks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4-2-53 , 19 57 , to 10-28 , 19 57 , that I last saw the deceased alive on 10-25 , 19 57 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Buckley Springs, Pa DATE SIGNED Herbert R. Tobias							
ACTUAL SIGNATURE Herbert R. Tobias M.D.							
PHYSICIAN'S NAME (Type) Herbert R. Tobias Buckley Springs, Pa							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10.30.57		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery Warfordsburg Fulton Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Hance Hancock Md				24a. REC'D BY REGISTRAR DATE 10/29/57		24b. REGISTRAR'S SIGNATURE J. A. Miller	

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		1910-10-10	
Place of Birth		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		1957-11-1	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

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RECEIVED

11211

CERTIFICATE OF DEATH

Reg. Dist. No.

11183

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rural Smithsburg X2			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Emory David BOWMAN				4. DATE OF DEATH Month Day Year Oct. 24. 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23. 1897		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David E. Bowman				14. MOTHER'S MAIDEN NAME Julia A. Tracey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 191-26-6840		17. INFORMANT Annie R. Bowman Smithsburg R.D. I MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URIE MIA 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NEPHROSCLEROSIS DUE TO (c) HYPERTENSIVE CARDIOVASCULAR-DISEASE INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 1 YEAR 5 YEARS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-29-57 , 19____, to 10-23-1957 , that I last saw the deceased alive on 10-23-57 , 19____, and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 117 W. Main St. Waynesboro, Va. 10-25-57							
ACTUAL SIGNATURE Ross S. Funch M.D.				PHYSICIAN'S NAME (Type) ROSS S. FUNCH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-57		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.		22d. LOCATION (City, town, or county) (State) near Smithsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE OCT 29 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

RECEIVED

OCT 29 1957

BUREAU V. S.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 333 Bryan Place				e. STREET ADDRESS 1 333 Bryan Place			
3. NAME OF DECEASED (Type or print) EMMA First Middle Last BRILL				4. DATE OF DEATH October 21 19 57 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 13, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 11 Days 8		IF UNDER 24 HRS. Hours 11 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Brill				14. MOTHER'S MAIDEN NAME Anna Suter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-4818		17. INFORMANT Mrs. Harold Fuller		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular, Eclampsia 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration (c) Dehydration							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death yes yes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1955 , 19 05 , to 1957 , that I last saw the deceased alive on 05 , 19 57 , and that death occurred at M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 119 E. Antietam St. Hagerstown, Md.				DATE SIGNED 10/21/57			
ACTUAL SIGNATURE Louis G. Graff							
PHYSICIAN'S NAME (Type) Louis G. GRAFF Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct 23/1957	
				24b. REGISTRAR'S SIGNATURE Phas H. Bowers			

CERTIFICATE OF DEATH

Page No. 302

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF DEATH 10-10-1957		PLACE OF DEATH Home	
RESIDENCE 1234 E. Main St., Baltimore, Md.		OCCUPATION Retired		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF BIRTH 10-10-1892		PLACE OF BIRTH Baltimore, Md.	
EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married		SPOUSE'S NAME Mary H. Harris		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE Baltimore, Md.	
PREVIOUS ILLNESS Hypertension		TREATMENT Physician		DATE OF LAST ILLNESS 10-01-1957		DATE OF DEATH 10-10-1957		DATE OF BURIAL 10-12-1957		PLACE OF BURIAL St. Mary's Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

BUREAU V. 2

OCT 28 1957

RECEIVED

Countersigned

S. Robert Wells

11166

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>149 King St</u>		d. STREET ADDRESS <u>149 King St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Low</u> Last <u>Carnochan Sr.</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Chillicothe Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Carnochan</u>		14. MOTHER'S MAIDEN NAME <u>Marian Low</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-7901</u>	
17. INFORMANT <u>John L. Carnochan Jr.</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>never saw him alive</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u>		ADDRESS (Street, city or town, state) <u>1135 Potomac Ave. Hag. Md.</u> DATE SIGNED <u>1 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown</u>	
24a. REC'D BY REGISTRAR <u>11/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>Paul H. Bowers</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1-1-1957

DECEASED

DATE OF DEATH

TIME OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

Handwritten notes and signatures in the center of the form.

Handwritten notes and signatures on the right side of the form.

BUREAU V. S.

JUN 12 1957

RECEIVED

JUN 11 - 57

Boots & Son

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or any designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11186

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cavetown		c. LENGTH OF STAY IN 1b 12 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg x0	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stone Quarry			d. STREET ADDRESS 68 W. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ronald Terry Cowan			4. DATE OF DEATH Month Day Year Oct. 13, 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1935		9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office mach. opr.		10b. KIND OF BUSINESS OR INDUSTRY aircraft ind.		11. BIRTHPLACE (State or foreign country) Greencastle, Pa.	
12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Earl O. Cowan			14. MOTHER'S MAIDEN NAME Ann Catherine Spessard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Active-1957		16. SOCIAL SECURITY NO. 214-30-1876		17. INFORMANT Earl O. Cowan, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull (open) 978x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					INTERVAL BETWEEN ONSET AND DEATH 15 min.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Jumped about 100 feet into stone quarry			
20c. TIME OF INJURY Month, Day, Year Hour Minute p. m. Oct. 13 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stone Quarry	
20f. (City or town) Rural Smithsburg, Wash		20g. (County) Md		20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells		M.D. S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		DATE SIGNED 10-15-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-16-57		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
22d. LOCATION (City, town, or county) Smithsburg, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE Oct 18 '57	
24b. REGISTRAR'S SIGNATURE Alfred					

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 18 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11167

CERTIFICATE OF DEATH

11187

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Randolph Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
f. STREET ADDRESS 112 Randolph Ave.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle LYDIA Last DAVIS				4. DATE OF DEATH Month October Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Keedysville, Wash. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram Snyder				14. MOTHER'S MAIDEN NAME Maryland Lucinda Gouff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-7014		17. INFORMANT J. Franklin Davis-112 Randolph Av.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease with 420.0 DUE TO myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 5 years +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Jan 15 , 19 47 , to 18 Oct , 19 57 , that I last saw the deceased alive on 18 Oct , 19 57 , and that death occurred at 1:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby		M.D. 230 N. Primmer St		ADDRESS (Street, city or town, state) Hagerstown Md.		DATE SIGNED 18 Oct 57	
PHYSICIAN'S NAME (Type) F. F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR 23 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowry	

OCT 23 1957
BUREAU V.

RECEIVED
OCT 23 1957

11168

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				d. STREET ADDRESS 118 W. Magnolia Ave.			
3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Davis				4. DATE OF DEATH Month October Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 15, 1871		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard Davis				14. MOTHER'S MAIDEN NAME Emma J. Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. C. R. Burger Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH approx 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/5/57 19 57 , to 10/26/ 19 57 , that I last saw the deceased alive on 10/25/57 19 57 , and that death occurred at 6:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 N. Potomac Hag. Md. DATE SIGNED 10/26/57 ACTUAL SIGNATURE Dr. David J. Boyer M.D. PHYSICIAN'S NAME (Type) Dr. David J. Boyer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hag. Md.		24a. REC'D BY REGISTRAR Oct. 29, 1957	
				24b. REGISTRAR'S SIGNATURE Wm. H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 31 1957

RECEIVED

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 900 Pennsylvania Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Dodson				4. DATE OF DEATH Month Oct. Day 14 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher A. Nichols				14. MOTHER'S MAIDEN NAME Fannie (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT M.H. Dodson Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/13/57 , to 10/14/57 , that I last saw the deceased alive on 10/14/57 , and that death occurred at 9:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 10/17/57 ACTUAL SIGNATURE Ralph E. Young M.D. William J. Ford							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct. 17, 1957	
				24b. REGISTRAR'S SIGNATURE Shirley Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED CHRISTOPHER J. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 37</p>		<p>4. DATE OF BIRTH OCT 21 1917</p>	
<p>5. PLACE OF BIRTH BALTIMORE, MARYLAND</p>		<p>6. OCCUPATION None</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>	
<p>9. EDUCATION High School</p>		<p>10. RELIGION Catholic</p>	
<p>11. CAUSE OF DEATH Myocardial Infarction</p>		<p>12. PLACE OF DEATH Home</p>	
<p>13. DATE OF DEATH OCT 21 1957</p>		<p>14. TIME OF DEATH 10:30 AM</p>	
<p>15. SIGNATURE OF PHYSICIAN J. H. HARRIS</p>		<p>16. SIGNATURE OF REGISTRAR J. H. HARRIS</p>	
<p>17. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>18. SIGNATURE OF WITNESS J. H. HARRIS</p>	

BUREAU V. 2

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190

Dr.G.LeVan

11213

CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 1 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Heeder Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle LESLIE Last DOUB				4. DATE OF DEATH Month October Day 31 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct.10,1861	9. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months 96 Days 96 Hours 96 Min.	IF UNDER 24 HRS. Months 96 Days 96 Hours 96 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Beaver Creek-Wash.Co.Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip R. Doub				14. MOTHER'S MAIDEN NAME Cornelia Witmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address M. Berry Doub - Clearspring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 17 , 19 57 , to Oct 31 , 19 57 , that I last saw the deceased alive on Oct 30 , 19 57 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. LeVan				ADDRESS (Street, city or town, state) Boonsboro Md.		DATE SIGNED 11/1/57	
PHYSICIAN'S NAME (Type) G. W. LeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-57		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Beaver Creek-Wash.Co.Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR DATE Nov. 7. 1957		24b. REGISTRAR'S SIGNATURE John H. Bask	

CERTIFICATE OF DEATH

St. O. Lewis

406

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. LEWIS		M		45		JAN 15 1890	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
ST. LOUIS, MO.		FIREMAN		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
JAN 20 1957		ST. LOUIS, MO.		JAN 22 1957		ST. LOUIS, MO.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
JAN 20 1957		ST. LOUIS, MO.		JAN 22 1957		ST. LOUIS, MO.	

BUREAU V. 1

NOV 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

11170

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Bittle Last Entler				4. DATE OF DEATH Month Oct. Day 20 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY house building		11. BIRTHPLACE (State or foreign country) Shepherdstown, W.Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John P. Entler				14. MOTHER'S MAIDEN NAME Amanda Hawn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Irene Hook, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) general arterio-sclerosis & cerebral 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) thrombosis & cerebral - vascular DUE TO (c) Accident - (5 weeks)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 1, 1954 , to Oct 20, 1957 , that I last saw the deceased alive on Oct 20, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto III M.D.				ADDRESS (Street, city or town, state) 217 W. Washington Street		DATE SIGNED 10/31/57	
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D., 217 W. Washington, Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-22-57	22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown, W.Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE Oct. 23, 1957		24b. REGISTRAR'S SIGNATURE John H. Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		40		M		W		1917		BALTIMORE, MD.	
DECEASED AT		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		OCT 28 1957		10:30 PM		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		PREVIOUS ILLNESS		NONE	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF DECEASED		DATE	
JAMES H. HARRIS		OCT 28 1957		JAMES H. HARRIS		OCT 28 1957		JAMES H. HARRIS		OCT 28 1957	
FAMILY PHYSICIAN		HOSPITAL		CITY		STATE		COUNTRY		ZIP CODE	
JAMES H. HARRIS		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
FAMILY PHYSICIAN		HOSPITAL		CITY		STATE		COUNTRY		ZIP CODE	
JAMES H. HARRIS		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	

BUREAU V. 5

OCT 28 1957

RECEIVED

11171

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 Yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 Jefferson Street			d. STREET ADDRESS 311 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benjamin Middle Franklin Last Favorite			4. DATE OF DEATH Month October Day 14, Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1872		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Foreman		10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone		11. BIRTHPLACE (State or foreign country) Smitheburg, Wash Co. USA	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Jack Favorite		
14. MOTHER'S MAIDEN NAME Clara DeLosier			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 212-05-0842			17. INFORMANT Address Mrs. Mary F. Favorite- 311 Jefferson St-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Thrombosis DUE TO 903.0 Carcinoma prostate with metastasis to rt femur Conditions, if any, which gave rise to immediate cause (b) Multiple fractures of pelvic bones (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 71 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell on the floor at home			
20c. TIME OF INJURY Month, Day, Year Hour 4 XXXX p. m. Aug. 4 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home	
20f. (City or town) Hagerstown		20g. (County) Wash		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-15-57	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Wash Co. Md		22e. (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman	
23a. ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Oct 17, 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172

CERTIFICATE OF DEATH

Reg. Dist. No. 302

11193

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First MARY Middle VIRGINIA Last FINAFROCK		4. DATE OF DEATH Month October Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1880
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 11 Days 27 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Franklin Co., Penn.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Knoll		14. MOTHER'S MAIDEN NAME Julia Keefer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Knoll Finafrock		Address St. Thomas, Pennsylvania	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL Asthma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to Oct , 19 57 , that I last saw the deceased alive on 1 Oct , 19 57 , and that death occurred at 9:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greencastle Pa. DATE SIGNED ACTUAL SIGNATURE Bl Webster M.D. Greencastle Pa. PHYSICIAN'S NAME (Type) 			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/1957	
22c. NAME OF CEMETERY OR CREMATORY Norland Cemetery		22d. LOCATION (City, town, or county) (State) Chambersburg, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE P. Franklin Boyer		24a. REC'D BY REGISTRAR Oct 7, 1957	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Chas H Bowers	

BUREAU V. S.

OCT 4 1957

RECEIVED

Dr. Hirshman, 11173 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 2 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hosp.				d. STREET ADDRESS Antietam Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HUMERICH HOUSE FISHER				4. DATE OF DEATH Month Day Year Oct. 11, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) MD Kemp's Mill-Wash. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joel S. Fisher				14. MOTHER'S MAIDEN NAME Louise Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. unable to locate		17. INFORMANT Address Mrs. Julia Spencer-242 E. Main St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO fibrosarcoma - Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerotic Heart Disease DUE TO several yrs. (c) Westminister, Maryland				INTERVAL BETWEEN ONSET AND DEATH Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Oct 18, 1947 , to Oct 11, 1957 , that I last saw the deceased alive on Oct 19, 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirshman		ADDRESS (Street, city or town, state) DATE SIGNED 159 W. Washington St. Hagerstown Md 10/12/57					
PHYSICIAN'S NAME (Type) Philip J. Hirshman		159 W. Washington St.-Hagerstown					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland			24a. REC'D BY REGISTRAR Oct 15, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Powers		

CERTIFICATE OF DEATH

1. NAME OF DECEASED CHARLES H. HARRIS		2. SEX MALE		3. AGE 45		4. RACE WHITE		5. DATE OF DEATH OCT 17 1957		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH HOME		8. CITY MEMPHIS		9. COUNTY SHARPS		10. STATE MISSISSIPPI		11. ZIP CODE 38101		12. MANNER OF DEATH NATURAL	
13. CAUSE OF DEATH HEART DISEASE		14. DISEASE OR INJURY MYOCARDIAL INFARCTION		15. INTERPRETER'S SIGNATURE <i>[Signature]</i>		16. MEDICAL EXAMINER'S SIGNATURE <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF WITNESSES <i>[Signature]</i>	
19. SIGNATURE OF REGISTRAR <i>[Signature]</i>		20. SIGNATURE OF CLERK <i>[Signature]</i>		21. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		22. SIGNATURE OF NURSE <i>[Signature]</i>		23. SIGNATURE OF CHURCH CLERGYMAN <i>[Signature]</i>		24. SIGNATURE OF OTHER <i>[Signature]</i>	

BUREAU V. A.

OCT 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG222 11-4-57 et

CERTIFICATE OF DEATH

11195

Reg. Dist. No.

302

11214

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown- rural				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gate Way Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rhoe MIT, Ida Fox				4. DATE OF DEATH Month Day Year October 21, 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1868	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Wilhide				14. MOTHER'S MAIDEN NAME Elmira (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Jesse Fox Thurmont, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Sclerotic Cardiac Dis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/30 , 19 56 , to 10/21 , 19 57 , that I last saw the deceased alive on 10/20 , 19 57 , and that death occurred at 9:59 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clear Spring 10/24/57 ACTUAL SIGNATURE David R. Brewer M.D. PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57		22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager & Son				24a. REC'D BY REGISTRAR DATE 25 1957		24b. REGISTRAR'S SIGNATURE Chas A Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071123

Spence, I. 1997.

not a child.

• 52 •

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93-3681-55-20

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BUREAU V. 5

OCT 25 1957

RECEIVED

Unit 10: The Great Wall

10-53-55

1922/23 2 500/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11174

CERTIFICATE OF DEATH

Reg. Dist. No. 302 11196

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 243 N. Potomac Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle GEARD Last FRANKLIN				4. DATE OF DEATH Month October Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1900	
9. AGE (In years last birthday) 56 yrs.		10. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Scranton, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Franklin				14. MOTHER'S MAIDEN NAME Mary Devers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-18-0798			
17. INFORMANT Mrs. Mary S. Franklin				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 705.4 DUE TO Lupus Erythematosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6-56 DUE TO Arterio-sclerotic Heart Disease (c) 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-21-1956 , to 10-13-1957 , that I last saw the deceased alive on 10-12-1957 , and that death occurred at 11 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Hagerstown Md			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED 10/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/1957		22c. NAME OF CEMETERY OR CREMATORY St. Mark's Episcopal Cem.		22d. LOCATION (City, town, or county) (State) Lewisburg, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Pitzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct 16. 1957	
24b. REGISTRAR'S SIGNATURE [Signature]							

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-1-1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
1000	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
4-4-1968		
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
...		

RECEIVED
BUREAU V. S.
 OCT 18 1957

11175

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 55 years				d. STREET ADDRESS 13 W. Baltimore St.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 W. Baltimore St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle A Last Haines				4. DATE OF DEATH Month Oct. Day 4 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1864	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) Uniontown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Haines				14. MOTHER'S MAIDEN NAME Mary Blacksten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT C. Wilbur Haines Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arterio-sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-1-57 , 19 57 , to 10-4 , 19 57 , that I last saw the deceased alive on 10-2-57 , 19 57 , and that death occurred at 8 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. W. Kraiss				DATE SIGNED 10-7-57			
PHYSICIAN'S NAME (Type) F. W. Kraiss				M.D. Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-6-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Address Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE Oct. 7, 1957		24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

11176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hagerstown, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 5				d. STREET ADDRESS 1 R # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Hause				4. DATE OF DEATH Month October Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1920	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Worker		10b. KIND OF BUSINESS OR INDUSTRY Fairchilds		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME D. Randall Hause				14. MOTHER'S MAIDEN NAME Nora French			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War #		16. SOCIAL SECURITY NO. 2 217-16-2736		17. INFORMANT Address Mrs. June Bowman Hause - R#5 Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Fever DUE TO Rheumatic Valvular heart disease Conditions, if any, which gave rise to immediate cause (b) Acute Coronary occlusion (c) Acute Coronary occlusion (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 13 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 10-18-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/1957		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Martin Poe ADDRESS Waynesboro, Penna.				24a. REC'D BY REGISTRAR OCT 21 1957 24b. REGISTRAR'S SIGNATURE Chas. H. Hower			

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Residence	
Date of Death		Place of Death	
Age		Sex	
Race		Religion	
Marital Status		Occupation	
Cause of Death		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Certificate		Place of Issuance	

BUREAU V. 2

OCT 21 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11199

Reg. Dist. No. 302

11177

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 03	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 32 Summit Ave.		d. STREET ADDRESS 132 Summit Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maurice F. Hickey		4. DATE OF DEATH Month Oct. Day 30 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1876
9. AGE (In years and birthday) 81 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) street dept.		10b. KIND OF BUSINESS OR INDUSTRY city of Hag.	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Peter Hickey		14. MOTHER'S MAIDEN NAME Johana Cuffe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) []		16. SOCIAL SECURITY NO. 217-09-9916A	
17. INFORMANT []		Address []	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular Hypertension 331X DUE TO Acute Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) [] (c) []			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. []	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Welle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Welle, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 11-1-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-4-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Nov. 1, 1957	
		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the information required by the law, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

CERTIFICATE OF DEATH

Reg. Dist. No.

302

11178

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 9 1/2 Hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 217 No Cannon Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN RAYMOND HUMMELSINE				4. DATE OF DEATH Month Day Year Oct 14 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 14 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Andrew Hummelsine				14. MOTHER'S MAIDEN NAME Lillie Florence-----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-8620		17. INFORMANT Address Mrs Lola C. Hummelsine 217 No Cannon Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic Heart Disease DUE TO (c) 420.0 INTERVAL BETWEEN ONSET AND DEATH 2 Wks 4 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1949 to Oct-14 , 19 57 , that I last saw the deceased alive on Oct 13 , 19 57 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 10/14/57							
ACTUAL SIGNATURE E. A. Hoffman		M.D. 214 N. Potomac St. Hagerstown, Md.					
PHYSICIAN'S NAME (Type) Hoyd A. Hoffman		Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/17/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			ADDRESS Hagerstown Md.				
24a. REC'D BY REGISTRAR Oct 17 1957		24b. REGISTRAR'S SIGNATURE Chas. Bowers					

18

1957 21 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

11179

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>HERBERT</u> Last <u>INGRAM</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>October 18, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinest Sup.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing plant</u>			
11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>William M. Ingram</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hendrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-0326</u>			
17. INFORMANT <u>Mrs. Doris Stone</u>				Address <u>Hagerstown Rt. # 3, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Jan. 1957</u> to <u>Oct. 8, 1957</u> , that I last saw the deceased alive on <u>Aug 10, 1957</u> , and that death occurred at <u>7 P-M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>10/9/57</u>							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Prager</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowser</u>	

CERTIFICATE OF DEATH

OCT 15 1957

RECEIVED

BUREAU V. S.

BUREAU V. 3

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11180

CERTIFICATE OF DEATH

11203

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1 544 Guilford Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Jeanette</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Harry Kountz</u>		14. MOTHER'S MAIDEN NAME <u>Eva M. Stouffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Leroy Jones</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of thyroid with</u> <u>194X</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>52</u> , to <u>Oct 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 W. Washington St. Hagerstown</u> DATE SIGNED <u>md.</u>			
ACTUAL SIGNATURE <u>Robert W. Campbell</u>		M.D. <u>145 W. Washington St. Hagerstown</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Robert Campbell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Walter H. Powers</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-27		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. DECEASED AT Baltimore, Md.		12. PLACE OF DEATH Home		13. DATE OF DEATH 4-4-68		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Suicide	
16. DISEASE OR INJURY Suicide		17. MANNER OF DEATH Suicide		18. PLACE OF INTERMENT None		19. DATE OF INTERMENT None		20. NAME OF FUNERAL HOME None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF WITNESS None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF CORONER None		25. SIGNATURE OF REGISTRAR None	

BUREAU A 1

OCT 10 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or inhumation.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11204	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 19 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1045 Florida Ave.					d. STREET ADDRESS 1 1045 Florida Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last KEESECKER					4. DATE OF DEATH Month Oct. Day 5 Year to 7 19 57						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1883		9. AGE (In years last birthday) 74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Cumberland, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-8378		17. INFORMANT Address Mrs. Marie Baughman Pheonix, Arizona							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Dr. E. W. J. P. Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Dr. E. W. J. P. Jr.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10/11/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer					ADDRESS Hagerstown, Md.			24a. REC'D BY REGISTRAR Oct. 12/1957		24b. REGISTRAR'S SIGNATURE Matthew Bowers	

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11182

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 352 Linganore Ave.,				d. STREET ADDRESS 352 Linganore Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Elmer Benjamin Kershner				4. DATE OF DEATH Month 10 Day 27 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1868		9. AGE (In years lost birthday) yrs. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer		10b. KIND OF BUSINESS OR INDUSTRY N.Y. Central Iron Wks		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vanlear Kershner				14. MOTHER'S MAIDEN NAME Mary Ellen Ringer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ira Kershner Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Myocardial Infarction DUE TO (b) Coronary Atherosclerotic Heart Disease 10 yrs DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 1 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/5/57, 19, to 10/27/57, 19, that I last saw the deceased alive on 10/25/57, 19, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE SEARL YOUNG				ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 10/28/57			
PHYSICIAN'S NAME (Type) SEARL YOUNG MD				HAGERSTOWN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-29-57		22c. NAME OF CEMETERY OR CREMATORY Broadfording		22d. LOCATION (City, town, or county) (State) Broadfording Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fred W. Kraiss Hagerstown, Md.				24a. REC'D BY REGISTRAR Oct. 31. 1957		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

NOV 4 1957

RECEIVED

11216

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>8 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Milva</u> Middle <u>Mae</u> Last <u>Kinsey</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Boonsboro, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>Dallas Ford</u>				14. MOTHER'S MAIDEN NAME <u>Prudence Hutzell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Robert L. Kinsey, Smithsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 22, 1957</u> to <u>Oct 23, 1957</u> ; that I last saw the deceased alive on <u>Oct 23, 1957</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert P. Conrad</u> M.D.				ADDRESS (Street, city or town, state) <u>137 W. Washington</u>			
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				DATE SIGNED <u>10-25-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Bast</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. DATE OF MARRIAGE [Illegible]</p>	
<p>9. NAME OF SPOUSE [Illegible]</p>		<p>10. DATE OF DEATH [Illegible]</p>	
<p>11. PLACE OF DEATH [Illegible]</p>		<p>12. CAUSE OF DEATH [Illegible]</p>	
<p>13. MEDICAL HISTORY [Illegible]</p>		<p>14. SIGNATURE OF PHYSICIAN [Illegible]</p>	
<p>15. SIGNATURE OF REGISTRAR [Illegible]</p>		<p>16. OFFICIAL SEAL [Illegible]</p>	

BUREAU V. 2

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

CERTIFICATE OF DEATH

Reg. Dist. No. 355

11207

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>Kline</u> Last <u>Kline</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Michael Kline</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Maugans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Juanita Weiss, Smithburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>57</u> , to <u>Oct 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 25</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Lwan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro -</u>		DATE SIGNED <u>10/28/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Gerald Levan</u>				<u>Boonsboro, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.B. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wolfsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Katherine Daguehart</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING 18

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

SEX: [illegible]

AGE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

MARRIAGE: [illegible]

PREVIOUS ILLNESS: [illegible]

PHYSICIAN: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

EXAMINER: [illegible]

REPORT: [illegible]

DATE OF REPORT: [illegible]

REPORTER: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

SEX: [illegible]

AGE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

MARRIAGE: [illegible]

PREVIOUS ILLNESS: [illegible]

PHYSICIAN: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

EXAMINER: [illegible]

REPORT: [illegible]

DATE OF REPORT: [illegible]

REPORTER: [illegible]

BUREAU V. S.

NOV 1 1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11208

Reg. Dist. No. 3021

11183

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE West Virginia . COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 hr			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Alexander Hotel Tap Room				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Martinsburg 85x-3			
f. STREET ADDRESS R # 3				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Leroy Last Lightner				4. DATE OF DEATH Month Oct. Day 18 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President				10b. KIND OF BUSINESS OR INDUSTRY Rose Dale Cemetery		11. BIRTHPLACE (State or foreign country) Union Bridge, Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Lightner				14. MOTHER'S MAIDEN NAME Emma Jane Hiltabidle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-01-8555		17. INFORMANT Address Mrs. Jack E. Sherrad- R#3 Martinsburg, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </p> </div> <div style="width: 15%; border: 1px solid black; padding: 2px;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) (County) (State) - - -							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY Rose Dale Cemetery		22d. LOCATION (City, town, or county) (State) R# 3 Martinsburg, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kogelschatz & Coffman</i> Kogelschatz & Coffman				ADDRESS Martinsburg, W. Va.		24a. REC'D BY REGISTRAR Oct 24 1957	
				24b. REGISTRAR'S SIGNATURE <i>W. H. H. H. H.</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for the files.

BUREAU V. 5

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11218

11209

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Security Md.</u>				c. LENGTH OF STAY IN 1b <u>Minutes</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Security Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Phyllis</u> Middle <u>Marie</u> Last <u>Malloy</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22 1930</u>		9. AGE (In years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ld Ailon Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Clearspring Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Carl Miles</u>				14. MOTHER'S MAIDEN NAME <u>Edna Eshelman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-9267</u>		17. INFORMANT <u>Mr. Robert Malloy</u> Address <u>Hagerstown, Md RF^D 6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Open Fracture skull</u> 810X DUE TO <u>Multiple fracture ribs</u> Conditions, if any, which gave rise to immediate cause (b) <u>Closed fracture ft. femur</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto- train collison</u>					
20c. TIME OF INJURY Hour <u>5:20</u> p. m. <u>Oct. 20 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R.R. Track-Security</u>		20f. (City or town) <u>Rural- Hagerstown Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leaf Williamsport</u>				24a. REC'D BY REGISTRAR <u>Oct 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shasth Powers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

Dr. SR Wells, 11184 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1111 Salem Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN EMERSON MARTIN				4. DATE OF DEATH Month Day Year October 26, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor-Penna.R.R.-Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chambersburg, Franklin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Martin				14. MOTHER'S MAIDEN NAME Mary C. Ebersole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 716-09-9418		17. INFORMANT Address Mrs. Nan C. Martin-1111 Salem Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lymph gland of neck 198x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic myocardial heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) -	(County) -	(State) -		
21. I certify that I attended the deceased from Dec. , 19 51 , to Oct. 26 , 19 57 , that I last saw the deceased alive on Oct. 22 , 19 57 , and that death occurred at 4:05 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells M.D.				ADDRESS (Street, city or town, state) 115 N. Potomac Street		DATE SIGNED 10-26-57	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-28-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR Oct 30 1957		24b. REGISTRAR'S SIGNATURE Wm H. Hoover	

BUREAU V. S.

NOV 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211

11185

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Mangansville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>1 Mangansville, md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Menno S. Martin</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1894</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Milnor, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-26-7348</u>		17. INFORMANT Address <u>Mrs. Mary Martin - Mangansville, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior Ischemic Heart Disease</u> DUE TO (c) <u>2 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1-</u> , 19 <u>57</u> , to <u>10-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-25-</u> , 19 <u>57</u> , and that death occurred at <u>1:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown md</u> DATE SIGNED <u>10/26/57</u> ACTUAL SIGNATURE <u>A. E. Minnich</u> M.D. <u>Agnes Martin</u> <u>10/26/57</u> PHYSICIAN'S NAME (Type) <u>A. E. Minnich</u> <u>Agnes Martin</u> <u>10/26/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>10/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Carfords, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich - Greencastle Pa.</u>				24a. REC'D BY REGISTRAR <u>10/27/57</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley Bowers</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS

DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

MASSACHUSETTS

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DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

BUREAU V. 3

OCT 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

11186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11212

Reg. Dist. No. 382

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 317 S. Potomac St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Mearl Last Martin				4. DATE OF DEATH Month 10 Day 25 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired guard		10b. KIND OF BUSINESS OR INDUSTRY Fairchilds		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Martin				14. MOTHER'S MAIDEN NAME Mary Alexander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-09-9316		17. INFORMANT Charles W. Martin Hughson, Calif.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Generalized vascular arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO Generalized vascular arteriosclerosis (c) 420.1 DUE TO Generalized vascular arteriosclerosis (c) 420.1						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-28-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-30-57		22c. NAME OF CEMETERY OR CREMATORY Brownsville		22d. LOCATION (City, town, or county) (State) Brownsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct 31 1957	
				24b. REGISTRAR'S SIGNATURE Sherry			



NOV 7 1957

RECEIVED

11187

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 143 WEST FRANKLIN ST.				e. STREET ADDRESS 809 FLORIDA AVENUE			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE ELIZABETH MORGAN				4. DATE OF DEATH Month Day Year OCTOBER 2 1957 19			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 10 1873	
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN FURRY				14. MOTHER'S MAIDEN NAME MARY WISSINGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT 809 FLORIDA AVENUE HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 53 , to Oct 2 , 19 57 , that I last saw the deceased alive on Oct 1 , 19 57 , and that death occurred at 4 1/2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac ST Hagerstown, Md DATE SIGNED 10-4-57							
ACTUAL SIGNATURE Paul Harrison		M.D. 318 N. Potomac ST					
PHYSICIAN'S NAME (Type) PAUL HARRISON		Hagerstown, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 5 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home ADDRESS Boonsboro Md				24a. REC'D BY REGISTRAR Oct 7 1957		24b. REGISTRAR'S SIGNATURE Wm H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. PAUL HARRISON 318 N. POTOMAC ST. HAGERSTOWN, MD.

BUREAU V. E.

11188

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Elmer</u> Last <u>Muritz</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>11</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>freight handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Middletown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Muritz</u>				14. MOTHER'S MAIDEN NAME <u>Anna Swisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-5192</u>		17. INFORMANT <u>Mrs. Effie Muritz, Smithsburg, Rd 2 M</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>1 1/2 years</u> <u>7 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>10</u> Day <u>19</u> Year <u>1957</u> Hour <u>10</u> a. m. <u>57</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>100 Professional Arts Bldg.</u>	
20f. (City or town) <u>Hagerstown</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Oct. 5</u> , 19 <u>57</u> , to <u>Oct. 16</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>Oct. 16</u> , 19 <u>57</u> , and that death occurred at <u>10:57 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>10/17/57</u>							
ACTUAL PHYSICIAN <u>William T. Layman, M.D.</u> PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>19/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11215

11189

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Route #5	
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDGAR Last MYERLY		4. DATE OF DEATH Month 10 Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Mary E. McKenney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-8676	
17. INFORMANT Mrs. Maud L. Myerly		Address R# 5 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Bronchiogenic DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 19 57, to Oct 12 19 57, that I last saw the deceased alive on Oct 11 19 57, and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell M.D.		ADDRESS (Street, city or town, state) 145 W Washington ST	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		DATE SIGNED 10/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR 10/14/57	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		BUSINESS		ART		SCIENCE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		OTHER			
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		MURDER		SUICIDE			
MANNER OF DEATH		NATURAL		ACCIDENT		HOMICIDE		SUICIDE		OTHER		UNKNOWN			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		OTHER			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER			
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		OTHER			

BUREAU V. S.

OCT 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11216

11219

CERTIFICATE OF DEATH

Reg. Dist. No.

207

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrotts Mills				c. LENGTH OF STAY IN 1b 8888			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Garrotts Mills				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Victoria Middle Almeda Last Myers				4. DATE OF DEATH Month 10 Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 57		IF UNDER 24 HRS. Months 8 Days 19 Hours 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard H. Luttrell				14. MOTHER'S MAIDEN NAME Eliza Jane Luttrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-34-0721		17. INFORMANT Roy Logue, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, emphysema, abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized abdominal arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-7-1957 , to 10-8-1957 , that I last saw the deceased alive on 10-8-1957 , and that death occurred at 6:40 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-9-57							
ACTUAL SIGNATURE C. E. FRUITT				M.D. Brunswick, Md			
PHYSICIAN'S NAME (Type) C. E. FRUITT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-57		22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Felt				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 14 1957	
24b. REGISTRAR'S SIGNATURE Katherine D. Rogers							

BUREAU V.

1957 1 1 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

CERTIFICATE OF DEATH

11217

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing home				d. STREET ADDRESS 102 Rowe St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle OVAC Last OVAC				4. DATE OF DEATH Month October Day 9 Year 1957			
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 7 Days 3	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tube miller				10b. KIND OF BUSINESS OR INDUSTRY Cement company		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-10-6908		17. INFORMANT Mrs. John Filipovitz Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 491X (b) Arteriosclerotic C V disease (c) Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days Unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 10 Day 10 Year 1957 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown, Md.				20g. (County) Hagerstown, Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Oct 10, 1955 , to Oct 9, 1957 , that I last saw the deceased alive on Oct 9, 1957 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. L. Packard Jr. M.D.				ADDRESS (Street, city or town, state) 145 W. Washington		DATE SIGNED 10/10/57	
PHYSICIAN'S NAME (Type) L. L. Packard Jr.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Hoyer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct-14-57	
				24b. REGISTRAR'S SIGNATURE Leroy M. Fochler (Deputy)			

CERTIFICATE OF DEATH

302

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. DATE OF DEATH [Illegible]		12. PLACE OF DEATH [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF WITNESS [Illegible]		15. SIGNATURE OF WITNESS [Illegible]	
16. SIGNATURE OF WITNESS [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]	
22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
25. SIGNATURE OF WITNESS [Illegible]		26. SIGNATURE OF WITNESS [Illegible]		27. SIGNATURE OF WITNESS [Illegible]	
28. SIGNATURE OF WITNESS [Illegible]		29. SIGNATURE OF WITNESS [Illegible]		30. SIGNATURE OF WITNESS [Illegible]	
31. SIGNATURE OF WITNESS [Illegible]		32. SIGNATURE OF WITNESS [Illegible]		33. SIGNATURE OF WITNESS [Illegible]	
34. SIGNATURE OF WITNESS [Illegible]		35. SIGNATURE OF WITNESS [Illegible]		36. SIGNATURE OF WITNESS [Illegible]	
37. SIGNATURE OF WITNESS [Illegible]		38. SIGNATURE OF WITNESS [Illegible]		39. SIGNATURE OF WITNESS [Illegible]	
40. SIGNATURE OF WITNESS [Illegible]		41. SIGNATURE OF WITNESS [Illegible]		42. SIGNATURE OF WITNESS [Illegible]	
43. SIGNATURE OF WITNESS [Illegible]		44. SIGNATURE OF WITNESS [Illegible]		45. SIGNATURE OF WITNESS [Illegible]	
46. SIGNATURE OF WITNESS [Illegible]		47. SIGNATURE OF WITNESS [Illegible]		48. SIGNATURE OF WITNESS [Illegible]	
49. SIGNATURE OF WITNESS [Illegible]		50. SIGNATURE OF WITNESS [Illegible]		51. SIGNATURE OF WITNESS [Illegible]	
52. SIGNATURE OF WITNESS [Illegible]		53. SIGNATURE OF WITNESS [Illegible]		54. SIGNATURE OF WITNESS [Illegible]	
55. SIGNATURE OF WITNESS [Illegible]		56. SIGNATURE OF WITNESS [Illegible]		57. SIGNATURE OF WITNESS [Illegible]	
58. SIGNATURE OF WITNESS [Illegible]		59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF WITNESS [Illegible]		62. SIGNATURE OF WITNESS [Illegible]		63. SIGNATURE OF WITNESS [Illegible]	
64. SIGNATURE OF WITNESS [Illegible]		65. SIGNATURE OF WITNESS [Illegible]		66. SIGNATURE OF WITNESS [Illegible]	
67. SIGNATURE OF WITNESS [Illegible]		68. SIGNATURE OF WITNESS [Illegible]		69. SIGNATURE OF WITNESS [Illegible]	
70. SIGNATURE OF WITNESS [Illegible]		71. SIGNATURE OF WITNESS [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]		75. SIGNATURE OF WITNESS [Illegible]	
76. SIGNATURE OF WITNESS [Illegible]		77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]		81. SIGNATURE OF WITNESS [Illegible]	
82. SIGNATURE OF WITNESS [Illegible]		83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. SIGNATURE OF WITNESS [Illegible]		87. SIGNATURE OF WITNESS [Illegible]	
88. SIGNATURE OF WITNESS [Illegible]		89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]		93. SIGNATURE OF WITNESS [Illegible]	
94. SIGNATURE OF WITNESS [Illegible]		95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]		99. SIGNATURE OF WITNESS [Illegible]	
100. SIGNATURE OF WITNESS [Illegible]		101. SIGNATURE OF WITNESS [Illegible]		102. SIGNATURE OF WITNESS [Illegible]	

RECEIVED
OCT 18 1957
BUREAU V. 1

11221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay R # 1				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Fairplay R # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairplay R # 1				d. STREET ADDRESS Fairplay R # 1			
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW JACKSON PAINTER				4. DATE OF DEATH Month Day Year 10 20 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/1862		9. AGE (In years last birthday) yrs. 94	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ca binet Maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Loudoun Co.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joushia Painter				14. MOTHER'S MAIDEN NAME Louise Clipp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Harold Near Fairplay, Md. Route # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Labor 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 57 , to 20 Oct , 19 57 , that I last saw the deceased alive on 20 Oct , 19 57 , and that death occurred at 3:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 21 Oct 57							
ACTUAL SIGNATURE Paul Haak		M.D. 28 West Potomac St. Williamsport, Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave.				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE Oct 24 1957	
				24b. REGISTRAR'S SIGNATURE John H. Post			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		54		M		W		1893		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		OCT 10 1957		BALTIMORE, MD.	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		DATE OF MARRIAGE		NAME OF SPOUSE	
HIGH SCHOOL		METHODIST		MARRIED		1915		JAN 15 1915		JANE HARRIS	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
NONE		OCT 5 1957		OCT 10 1957		10:00 AM		10:00		00	
ATTENDING PHYSICIAN		PATHOLOGIST		CORONER		MEDICAL EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	
DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		OCT 10 1957		BALTIMORE, MD.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF REGISTRAR	

RECORDED

RECEIVED
OCT 28 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190

CERTIFICATE OF DEATH

Dr. J. Wilson
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>1819 Mulberry Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Leroy</u> Last <u>Piper</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector-Pangborn-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saxton-Bedford Co. Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William L. Piper</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Sheets</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6133</u>	
17. INFORMANT <u>Mr Paul L Piper</u>		Address <u>Pittsburgh, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ex. city from Angerone Rt Leg.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Years.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>Sept.</u> Day <u>23</u> Year <u>1957</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 19, 1957</u> to <u>23 Oct. 1957</u> , that I last saw the deceased alive on <u>23 Oct. 1957</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>10/25/57</u>			
ACTUAL SIGNATURE <u>J. D. Wilson</u>		M.D. <u>J. D. WILSON, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md</u>	
24a. REC'D BY REGISTRAR <u>Oct. 28, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Coe</u>	

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KARLA Middle MARIA Last QUINN				4. DATE OF DEATH Month October Day 11 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1957		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	IF UNDER 24 HRS. Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James J. Quinn			14. MOTHER'S MAIDEN NAME Jeanne E. Clark				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. James J. Quinn Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.9.57 , 19____, to 10.11.57 , 19____, that I last saw the deceased alive on 10.11.57 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md DATE SIGNED 10.11.57 ACTUAL SIGNATURE Searly Young M.D. PHYSICIAN'S NAME (Type) SEARLY YOUNG M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Royer Suter-Rouzer Funeral Home ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Oct. 13. 1957		24b. REGISTRAR'S SIGNATURE Phyllis Roovers	

ARABIAN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

OCT 15 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11222
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G222 11-14-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 308

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock 2 c. LENGTH OF STAY IN 1b 1Yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural 2 Hancock Maryland. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ricky Middle Glenn Last Ray		4. DATE OF DEATH Month 10. Day 25 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-55 9. AGE (In years lost birthday) 1 yrs. 11 months 13 days 19 hours 57 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Berkeley County W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glenn A Ray		14. MOTHER'S MAIDEN NAME Lucille R Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Glenn A Ray Rural 2 Hancock Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Virus Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25, 1957 , to Oct 25, 1957 , that I last saw the deceased alive on Oct 25, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hancock Md DATE SIGNED 10/27/57 ACTUAL SIGNATURE L.M. Shaffer M.D. PHYSICIAN'S NAME (Type) L.M. SHAFER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.28.57	
22c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Near Hancock Washington MD	
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Leone		24a. REC'D BY REGISTRAR Howard F. Leone 24b. REGISTRAR'S SIGNATURE Howard F. Leone DATE 10/28/57	

W. ARTHUR STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

OCT 30 1957

RECEIVED

11223

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) APPLETOWN RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) APPLETOWN RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. ROUTE 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE E. RICE				4. DATE OF DEATH Month Day Year OCT. 9 1957 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9 1911	9. AGE (In years last birthday) yrs. 46	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER WASH. CO. ROAD DEPT.				10b. KIND OF BUSINESS OR INDUSTRY LOCUST GROVE WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SAMUEL C. RICE				14. MOTHER'S MAIDEN NAME META M. CROWL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-10-3071		17. INFORMANT Address MRS. GRACE RICE BOONSBORO MD. ROUTE 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 9 , 19 57 , to Oct 9 , 19 57 , that I last saw the deceased alive on Oct 9 , 19 57 , and that death occurred at 8 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Van				ADDRESS (Street, city or town, state) Boonsboro			
PHYSICIAN'S NAME (Type) G. W. Van				DATE SIGNED 10/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 12 1957		22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home Boonsboro Md				24a. REC'D BY REGISTRAR DATE Oct. 12, 1957		24b. REGISTRAR'S SIGNATURE John H. Bask	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11223

11192

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 28 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 621 Guilford Ave.		d. STREET ADDRESS 621 Guilford Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUTH First Middle MARGUERITE Last RICKRODE		4. DATE OF DEATH Month October Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Crist		14. MOTHER'S MAIDEN NAME Mary Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Louis Rickrode		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Aneurysm 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH sudden 8 yrs. 8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 24, 1957 to Oct 10, 1957 , that I last saw the deceased alive on Oct 24, 1957 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thos. J. Mosliman M.D.		ADDRESS (Street, city or town, state) 1594 Washington St Hagerstown Md DATE SIGNED Oct 9/1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/1957	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Ronger		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct. 12, 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
October 10, 1957		Home		Heart Disease	
Time of Death		Physician		Manner of Death	
10:00 AM		Dr. J. Smith		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Address of Deceased		City		State	
123 Main St.		Baltimore		MD	
Occupation		Education		Marital Status	
Teacher		High School		Married	
Previous Illnesses		Previous Injuries		Previous Operations	
Hypertension		None		None	
Family History		Social History		Habitual Habits	
None		None		None	
Burial Place		Burial Date		Burial Time	
Catholic Cemetery		October 12, 1957		11:00 AM	
Burial Place		Burial Date		Burial Time	
Catholic Cemetery		October 12, 1957		11:00 AM	

BUREAU V. S.

OCT 15 1957

RECEIVED

11193 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 15 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 51 West Franklin St				e. STREET ADDRESS 51 West Franklin St			
3. NAME OF DECEASED (Type or print) First BETTIE Middle --- Last RUBEN				4. DATE OF DEATH Month Oct Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseswork		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max Ruben				14. MOTHER'S MAIDEN NAME Lena Simon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Aaron S. Ruben 1133 Hamilton Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease (c) Suspected Carcinoma of ovary.							INTERVAL BETWEEN ONSET AND DEATH Suddenly 4 yrs. 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown		(County) Washington		(State) Md.
21. I certify that I attended the deceased from Nov. 23 , 19 35 , to Oct 9 , 19 57 , that I last saw the deceased alive on Oct 9 , 19 57 , and that death occurred at 5A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirschman				DATE SIGNED Oct 11 1957			
PHYSICIAN'S NAME (Type) PHILIP J. HIRSCHMAN				M.D. 150 W. Washington St. Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 11-1957	22c. NAME OF CEMETERY OR CREMATORY B'nai Abraham Cemetery Hagerstown Wash. Co Md		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. REC'D BY REGISTRAR Oct 11 1957		24b. REGISTRAR'S SIGNATURE Chas. A. Bowers	

BUREAU V. 5

1957 14 OCT

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11225
302
Reg. Dist. No.

11194

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 60yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 136 William Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Curtis Henry Scott				4. DATE OF DEATH Month 100 Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25 1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Hagerstown Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Scott				14. MOTHER'S MAIDEN NAME Mary Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Jane Scott Address 136 William Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO + hypertensive vascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible pneumoconiosis - or pulmonary cyst							INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1955 to Oct. 25, 1957 that I last saw the deceased alive on Oct 27, 1957 , and that death occurred at 9 00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Maryland DATE SIGNED 10/30/57							
ACTUAL SIGNATURE Edward W. Ditto M.D.				PHYSICIAN'S NAME (Type) Edward W. Ditto 111, M.D. 217 W. Washington St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 20-28-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR Nov. 1, 1957		24b. REGISTRAR'S SIGNATURE Sharr H. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195

CERTIFICATE OF DEATH

Reg. Dist. No. 11226

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 404 Linganore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERMAN Middle DAVID Last SHANK		4. DATE OF DEATH Month 10 Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1906
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milk receiving station		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willia m S.Shank		14. MOTHER'S MAIDEN NAME Nettie C.Carbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-0049	
17. INFORMANT Mrs.Herman Shank		Address 404 Linganore Ave. Hagerstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour Unknown.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8.1.34 , 19____, to 10.16.57 , 19____, that I last saw the deceased alive on 10.15.57 , 19____, and that death occurred at 8.30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE S.Earl Young M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) S.Earl Young M.D.		148 N.Potomac St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/18/57	22c. NAME OF CEMETERY OR CREMATORY Breadfording Cemetery	22d. LOCATION (City, town, or county) (State) Breadfording, Washington Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct 18 1957		24b. REGISTRAR'S SIGNATURE Shast Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

701 21 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Monree- R # 1 Boonsboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -				d. STREET ADDRESS R # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Otho James Middle Shifler Last -				4. DATE OF DEATH Month Oct. Day 12 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1893		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Boonsboro, Md R # 1		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Otho Shifler				14. MOTHER'S MAIDEN NAME Arbelia Doub			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. # 1		17. INFORMANT Mr. Ralph E. Shifler - Halfway, Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 974X (c) 774X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) Hanged self in corn crib at home					
20c. TIME OF INJURY Hour 6 2030X p. m. Month, Day, Year Oct. 12 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Rural Boonsboro, Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-57		22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.				24a. REC'D BY REGISTRAR DATE Oct. 15, 1957		24b. REGISTRAR'S SIGNATURE John H. Bad	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Race		Marital Status		Occupation		Usual Residence	
Place of Birth		Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Medical History		History of Present Illness	
Postmortem Examination		Autopsy		Toxicology		Other	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	

BUREAU V. E.

OCT 17 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring R 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Clearspring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Cline Last Shupp		4. DATE OF DEATH Month 10 Day 25 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1876
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Hose		14. MOTHER'S MAIDEN NAME Lydia Vandrew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edward Shupp		Address Clearspring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage (c) Senile arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 10 mo 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1-1956, to 10-25-1957, that I last saw the deceased alive on 10-24-57, 19, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. E. W. Kraiss		DATE SIGNED 10/26/57	
PHYSICIAN'S NAME (Type) Dr. E. W. Kraiss		M.D. Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-28-57	22c. NAME OF CEMETERY OR CREMATORY St. Pauls	22d. LOCATION (City, town, or county) (State) Hagerstown Rural Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE Oct 30-57		24b. REGISTRAR'S SIGNATURE J. W. Murray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John V. Smith</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF BIRTH <i>Jan 15, 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>	
OCCUPATION <i>Engineer</i>		MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
DATE OF DEATH <i>Nov 10, 1957</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
DATE OF REPORT <i>Nov 12, 1957</i>		REPORTED BY <i>Dr. J. H. Jones</i>		SIGNATURE OF REPORTER <i>[Signature]</i>	
DATE OF INTERVIEW <i>Nov 12, 1957</i>		INTERVIEWED BY <i>Dr. J. H. Jones</i>		SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
DATE OF REVIEW <i>Nov 15, 1957</i>		REVIEWED BY <i>Dr. J. H. Jones</i>		SIGNATURE OF REVIEWER <i>[Signature]</i>	
DATE OF FINAL REVIEW <i>Nov 18, 1957</i>		FINAL REVIEWED BY <i>Dr. J. H. Jones</i>		SIGNATURE OF FINAL REVIEWER <i>[Signature]</i>	

BUREAU V. 3

NOV 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

11229

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 735 Dale St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEAN Middle MAY Last SISLER		4. DATE OF DEATH Month 10 Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/41
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 10 Days 17 Hours 19 Min. 57	11. IF UNDER 24 HRS. Months 10 Days 17 Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frances E. Sisler Sr.		14. MOTHER'S MAIDEN NAME Mildred May Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Frances E. Sisler R #1		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Status Asthmaticus & GRAND MALE 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 10/16/57 , 19____, to 10/17/57 , 19____, that I last saw the deceased alive on 10/17/57 , 19____, and that death occurred at 7:05 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Young M.D.		DATE SIGNED 10/17/57	
PHYSICIAN'S NAME (Type) Ralph F. Young M.D.		101 E. Potomac St. Williamsport, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1		22b. DATE THEREOF 10/20/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave.		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct. 19, 1957		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

CERTIFICATE OF DEATH

11102

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES				APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES			
MARRIAGE		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
OCCUPATION		BUSINESSMAN		LABORER		FARMER		MILITARY		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
CAUSE OF DEATH		HEART DISEASE		CANCER		TUBERCULOSIS		PNEUMONIA		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
CERTIFICATE OF DEATH		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION	

BUREAU V. F.
OCT 22 1957

RECEIVED

11226

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b 23 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HIGH STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last SMITH				4. DATE OF DEATH Month OCTOBER Day 18 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2 1866		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH.CO.MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ANDREW W. SMITH				14. MOTHER'S MAIDEN NAME ELIZABETH PALMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ROY SMITH HIGH ST. BOONSBORO MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10 , 19 57 , to Oct 18 , 19 57 , that I last saw the deceased alive on Oct 17 , 19 57 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Wilevan				ADDRESS (Street, city or town, state) Boonsboro Md.			
PHYSICIAN'S NAME (Type) G. Wilevan				DATE SIGNED 10/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 20 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East End Home Boonsboro Md				24a. REC'D BY REGISTRAR DATE Oct 20 1957		24b. REGISTRAR'S SIGNATURE John H. Paul	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. N.

1957 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11231

11227

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 RURAL CLEAR SPRING RTI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAYETTE EMERSON SMITH SR.</u>				4. DATE OF DEATH Month Day Year <u>10 I 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) yrs. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W, M, R, R.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT L. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>EDA RIDGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>705-10-4800RS.</u>		17. INFORMANT Address <u>WOLLA SMITH CLEAR SPRING RTI</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 16, 1955</u> to <u>Oct 1, 1957</u> that I last saw the deceased alive on <u>Oct 1, 1957</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>10/1/57</u>							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARK HEAD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clear Spring, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 10/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>Leroy M. Fickler</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228

CERTIFICATE OF DEATH

11232

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg				c. LENGTH OF STAY IN 1b 86 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 E. Main Street				e. STREET ADDRESS 116 E. Main Street			
3. NAME OF DECEASED (Type or print) First DAISY Middle SWAIN Last SWAIN				4. DATE OF DEATH Month Oct. Day 20 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 6 Days 8 Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sharpsburg Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Swain				14. MOTHER'S MAIDEN NAME Elizabeth Highberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles Mc Graw		Address 116 E. Main St. Sharpsburg Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 480x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive, arteriosclerotic cardio-vascular-renal disease							19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 7 19 57 to October 20 19 57 , that I last saw the deceased alive on Oct. 20, 1957 and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter H. Shealy				ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 10/21/57			
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md				24a. REC'D BY REGISTRAR DATE Oct 23-57		24b. REGISTRAR'S SIGNATURE E. J. Boyer	

CERTIFICATE OF DEATH

WATLAND STATE DEPARTMENT OF HEALTH - BALTIC, MD

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG222 10-29-57 et

CERTIFICATE OF DEATH

11233

Reg. Dist. No. 302

11197

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 341 N. Jonathan Street			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary		First Allison		Last Tate		4. DATE OF DEATH Month Oct Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Statesville, N.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Abner Allison				14. MOTHER'S MAIDEN NAME Raeley Allison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James Tate Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Voluntus of Colon 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rephroclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 27, 1957 , to Oct 17, 1957 , that I last saw the deceased alive on Sept 16, 1957 , and that death occurred at 1 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W Washington St Hagerstown Md DATE SIGNED 10/19/57 ACTUAL SIGNATURE Philip J. Hirshman M.D. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 21 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md				24a. REC'D BY REGISTRAR Oct 21 1957		24b. REGISTRAR'S SIGNATURE Chas H Bowers	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. E.

OCT 23 1957

RECEIVED

11198

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>N. 8. N. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>KIM</u> Middle <u>S.</u> Last <u>TOMS</u>				4. DATE OF DEATH Month <u>OCT-28-</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT-27-1957</u>	
9. AGE (In years last birthday) <u>762.5</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W-ONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>WASH. CO. HOSPITAL HAGERSTOWN MD. USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>KENNETH TOMS</u>				14. MOTHER'S MAIDEN NAME <u>JEANET VIRGINIA BOWARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>KENNETH TOMS</u> Address <u>BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary atelectasis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH --
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27</u> , 19 <u>57</u> to <u>Oct. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 27</u> , 19 <u>57</u> , and that death occurred at <u>12:05A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington St.</u> DATE SIGNED <u>10/28/57</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT-29-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>BOONSBORO MD OCT-29-1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Boward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

OCT 31 1957

RECEIVED

BUREAU K. A.

1

100-112042

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 10-10-2001 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235

11199

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rural - Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>RD 4 - Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence W. Weaver</u>				4. DATE OF DEATH <u>Oct 1, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Upton Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth C. Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Annie Weaver</u> Address <u>RD 4 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/30/57</u> , 19 <u>57</u> , to <u>10/1/57</u> , that I last saw the deceased alive on <u>10/1/57</u> , 19 <u>57</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reese F. Young</u>		M.D. <u>William J. Bowers</u> ADDRESS (Street, city or town, state) <u>10/3/57</u>					
PHYSICIAN'S NAME (Type) <u>A.E. Munnich - Greencastle Pa.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich - Greencastle Pa.</u>				24a. REC'D BY REGISTRAR <u>Oct 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED: *John A. Jones*
 SEX: *Male* AGE: *45*
 DATE OF BIRTH: *1910*
 PLACE OF BIRTH: *St. Louis, Mo.*
 OCCUPATION: *Engineer*
 CAUSE OF DEATH: *Heart Disease*
 PLACE OF DEATH: *Home*
 DATE OF DEATH: *Oct 1, 1957*
 TIME OF DEATH: *10:30 AM*
 SIGNATURE OF PHYSICIAN: *[Signature]*
 SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 3

OCT 7 1957

RECEIVED

11229

CERTIFICATE OF DEATH

11236
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown R.F.D. #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Wells</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Small</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Hicks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. William Wells</u> Address <u>Mt. View Trailer Court Hagerstown Md RFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Day</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/24/57</u> to <u>10/25/57</u> , that I last saw the deceased alive on <u>10/25/57</u> , and that death occurred at <u>4:45</u> M from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Dr. J. P. Young</u> M.D. <u>William Wells</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Wells</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Oct 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Powers</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The form is mostly blank with some faint, illegible markings.

Handwritten signature: Robert H. Lewis

BUREAU V. 21

Oct 31 1957

RECEIVED

Handwritten signature: Robert H. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

CERTIFICATE OF DEATH

11237

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Co. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. county Hospital				d. STREET ADDRESS 1480 Jefferson Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORMAN Middle FREDERICK Last WHITMER				4. DATE OF DEATH Month Oct Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 19 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower		10b. KIND OF BUSINESS OR INDUSTRY Neon Sign Co	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fred J. Whitmer		14. MOTHER'S MAIDEN NAME Esther Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-16-3546		17. INFORMANT Mrs Elizabeth S. Whitmer		Address 1480 Jefferson Blvd Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic stenosis (c) Decompensation				INTERVAL BETWEEN ONSET AND DEATH 2 wks years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 , 19 57 , to 1 Oct , 19 57 , that I last saw the deceased alive on 1 Oct , 19 57 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W. Wash. 12th DATE SIGNED 10/2/57							
ACTUAL SIGNATURE Edwin S. Hoachon M.D.		PHYSICIAN'S NAME (Type) Edwin S. Hoachon Hagerstown Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 3 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Oct 3 1957	
				24b. REGISTRAR'S SIGNATURE Chas H. Bowers			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		MARITAL STATUS [Illegible]	
PREVIOUS ILLNESS [Illegible]		PREVIOUS SURGERY [Illegible]		PREVIOUS TRAUMA [Illegible]	
PREVIOUS DRUGS [Illegible]		PREVIOUS ALCOHOL [Illegible]		PREVIOUS TOBACCO [Illegible]	
PREVIOUS RADIATION [Illegible]		PREVIOUS CHEMICALS [Illegible]		PREVIOUS OTHER [Illegible]	
PREVIOUS INJURY [Illegible]		PREVIOUS DISEASE [Illegible]		PREVIOUS TREATMENT [Illegible]	
PREVIOUS HOSPITALIZATION [Illegible]		PREVIOUS PHYSICIAN [Illegible]		PREVIOUS NURSE [Illegible]	
PREVIOUS LABORATORY [Illegible]		PREVIOUS X-RAY [Illegible]		PREVIOUS OTHER [Illegible]	
PREVIOUS OTHER [Illegible]		PREVIOUS OTHER [Illegible]		PREVIOUS OTHER [Illegible]	

BUREAU V. 2

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11238

Dr. Ralph Young 11201 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 433 West Washington St.				e. STREET ADDRESS 433 West Washington St.			
3. NAME OF DECEASED (Type or print) First EDNA Middle RUTH Last WINGERD				4. DATE OF DEATH Month October Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Sept. 23, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wolf				14. MOTHER'S MAIDEN NAME Alice Saum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Roy B. Wingerd-560 Salem Ave.-Hagersto			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 10/24/57 , 19 57 , to 10/25/57 , that I last saw the deceased alive on 10/25/57 , 19 57 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph F. Young				DATE SIGNED 10/26/57			
PHYSICIAN'S NAME (Type) Ralph F. Young				M.D. William A. Fort, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-27-57	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR Oct. 23, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Powers	

WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V.

OCT 30 1957

RECEIVED

11202

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 1 hour				d. STREET ADDRESS 28 E. Washington Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle LYDIA Last WOODYATT				4. DATE OF DEATH Month October Day 26 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 10 Days 26 Hours Min. 		IF UNDER 24 HRS. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Nevago, Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Marcus Leith				14. MOTHER'S MAIDEN NAME Eliza Augerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Blanche Durkee Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO 175X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma ovary with abdominal metastasis. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 week 8 months (history)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 5 , 19 57 , to Oct. 26 , 19 57 , that I last saw the deceased alive on October 23 , 19 57 , and that death occurred at 10:15 M. from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 10-28-57							
ACTUAL SIGNATURE William T. Layman, M.D.				M.D. 100 Professional Arts Bldg.			
PHYSICIAN'S NAME (Type) William T. Layman, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/1957		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer				ADDRESS Hagerstown, Md.		24a. REG'D BY REGISTRAR Oct. 31, 1957 24b. REGISTRAR'S SIGNATURE Blanche Durkee	

CERTIFICATE OF DEATH

Form No. 10-508

PLACE OF DEATH		MARRIAGE	
Washington County, Maryland		None	
Date of Death		Date of Marriage	
November 10, 1957		None	
Time of Death		Time of Marriage	
10:30 AM		None	
Cause of Death		Cause of Death	
Heart Disease		Heart Disease	
Immediate Cause		Immediate Cause	
Myocardial Infarction		Myocardial Infarction	
Underlying Cause		Underlying Cause	
Hypertension		Hypertension	
Contributing Cause		Contributing Cause	
None		None	
Manner of Death		Manner of Death	
Natural		Natural	
Accident		Accident	
Suicide		Suicide	
Homicide		Homicide	
Undetermined		Undetermined	
Other		Other	
None		None	
Age at Death		Age at Death	
65		65	
Sex		Sex	
Male		Male	
Race		Race	
White		White	
Birth Date		Birth Date	
November 10, 1957		November 10, 1957	
Birth Place		Birth Place	
Washington County, Maryland		Washington County, Maryland	
Occupation		Occupation	
None		None	
Education		Education	
None		None	
Religion		Religion	
None		None	
Marital Status		Marital Status	
None		None	
Previous Illnesses		Previous Illnesses	
None		None	
Previous Injuries		Previous Injuries	
None		None	
Previous Operations		Previous Operations	
None		None	
Previous Hospitalizations		Previous Hospitalizations	
None		None	
Previous Deaths		Previous Deaths	
None		None	
Previous Burials		Previous Burials	
None		None	
Previous Cremations		Previous Cremations	
None		None	
Previous Autopsies		Previous Autopsies	
None		None	
Previous Corsections		Previous Corsections	
None		None	
Previous Dissections		Previous Dissections	
None		None	
Previous Examinations		Previous Examinations	
None		None	
Previous Postmortems		Previous Postmortems	
None		None	
Previous Autopsies		Previous Autopsies	
None		None	
Previous Corsections		Previous Corsections	
None		None	
Previous Dissections		Previous Dissections	
None		None	
Previous Examinations		Previous Examinations	
None		None	
Previous Postmortems		Previous Postmortems	
None		None	

RECEIVED
NOV 4 1957
BUREAU V. 1